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CARE FOR INMATES WITH MENTAL ILLNESS: WHAT CAN NURSES DO?

by

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CARE FOR INMATES WITH MENTAL ILLNESS

Abstract

This paper serves to inform nurses of the medical and psychiatric treatment that inmates with mental illness receive and to offer suggestions for treatment interventions. Current practice includes mental health screens, psychotropic medication administration, psychiatric departments, and administrative segregation. The recommended interventions include providing therapy (including Cognitive Behavioral Therapy and Group Therapy), decreasing administrative segregation, implementing reintegration programs, and training and collaborating with correctional officers.

CARE FOR INMATES WITH MENTAL ILLNESS

Care for Inmates with Mental Illness: What Can Nurses Do?

“God was the parent, but He was also the policeman, the criminal, the maniac, and the judge” (Greene, 1940, p. 101). In his novel, *The Power and the Glory*, Graham Greene contends that God bestows his image not only on the clean, the uncontroversial, and the good, but also on the dirty, the criminal, and the maniac. If even these bear the image of God, then even these are human and deserve to be treated as such. It is the nurse’s duty to treat all patients holistically with the best care available. However, there remains a vulnerable population that is oft neglected—even despised—by health care professionals. Mentally ill inmates (that is, “the criminal” and “the maniac”) are not receiving care that is consistent with nursing standards. Thus, the purpose of this paper is to determine the efficacy of current treatment and what alternative methods of treatment and interventions, grounded in evidence-based practice, can be implemented to improve patient outcomes. Given that mentally ill inmates are human beings and that nurses have a duty to provide excellent care, nurses must ask: Is the current medical and psychiatric treatment of inmates with mental illness effective? And if not, what can nurses do?

Definitions

The first terms to define are jails and prisons. Jails and prisons are both addressed in this paper, but they are not synonymous. Jails typically house those who are sentenced to less than one year or are awaiting trial, sentencing, or transfer to prison (Office of Financial Management, 2014). Prisons, on the other hand, are for inmates sentenced to longer periods of incarceration which exceed one year (Office of Financial Management, 2014). Furthermore, different levels of government preside over jails and prisons. While prisons primarily fall under the jurisdiction of the state or federal government, jails can be run by states, cities, counties, or tribes (Office of Financial Management, 2014). The second term to define is mental illness. According to

Varcarolis (2017) mental illness refers to a dysfunction of the brain and neurotransmitters that impacts how a person functions, including how they think, feel, or interact with and relate to others. Individuals who have a mental illness and are in jail or prison are referred to as inmates with mental illness or mentally ill inmates.

Significance

In the United States, 2.2 million individuals are incarcerated (Daniel, 2007) and over half of them suffer from mental health problems (James & Glaze, 2006). James and Glaze (2006) define a mental health problem as a clinical diagnosis of mental illness or treatment by a mental health professional. Because over half of the U.S. incarcerated population meet the criteria for mental health problems, it is imperative that the country examine the effectiveness of medical and psychiatric treatment provided for inmates with mental illness. In 2005, it was reported that 56% of state prisoners, 45% of federal prisoners, and 64% of jail inmates had mental health problems (James & Glaze, 2006), culminating in about 1,264,300 mentally ill inmates, as estimated by the Bureau of Justice Statistics (2005). These numbers are staggering and demonstrate the necessity of intervention on behalf of mentally ill inmates.

Evaluating the care provided for inmates with mental illness is also significant because evidenced-based practice is the cornerstone of nursing care. In order to know what care to provide, nurses must know which nursing interventions work. Thus, evaluation of a system for efficacy is a necessary step in accomplishing any nursing goal. If the evaluation of the criminal justice system's care of mentally ill inmates produces evidence showing that it is ineffective, then nurses must change the system in order to implement the most effective, evidence-based care. Thus, nurses require evidence based on sound evaluation methods to do their jobs.

Finally, this topic is significant to nurses because provision 8.1 of the *Code of Ethics for Nurses* states that “health is a universal right” (American Nurses Association, 2015). The universe does not end where the cell door begins. Thus, nurses must work to ensure that this universal right of health is extended to those who are in prisons and jails. It is not right to deprive an inmate of health when health is an inmate’s right. Furthermore, based on the ethical principle of justice, nurses have a duty to promote just and equitable treatment of vulnerable populations. Mentally ill inmates need nurses to advocate for their right to health and just treatment.

Background

The reasons behind the high number of inmates with mental health conditions are rooted in the historic move from detaining mentally ill individuals in institutions to criminalizing them. From the late eighteenth to early nineteenth century in the U.S., mentally ill delinquents were routinely sent to prisons and jails (Torrey et al., 2014). Authorities recognized that this was a faulty system and thus from 1820-1970, mental institutions became the primary housing of the mentally ill (Torrey et al., 2014). However, rumors of institutional abuses began to spread and after investigation into their practices, mental institutions began to be shut down across the nation. Additionally, the closing of the institutions was augmented by the advent of psychotropic medications (Baillargeon, Binswanger, Penn, Williams, & Murray, 2009). With medication to control the more overt symptoms of mental illness that many perceived as dangerous, patients were safe and free to be released. Had there been a community-based system to replace the function of mental institutions in case of need, this may have worked (Brandt, 2012). Unfortunately, no such plan was put in place and thus, jails and prisons once again became the de facto mental institutions (Torrey et al., 2014). Because there is little treatment available in the community, mentally ill individuals end up in correctional facilities. This is problematic because

U.S. jails and prisons were not orchestrated to treat people, but to punish them (Brandt, 2012). Nevertheless, because jails and prisons are some of the few places that can—and cannot refuse to—detain individuals with mental illness, they are inundated with the mentally ill (Torrey et al., 2014).

The high numbers of mentally ill individuals in the criminal justice system do not reflect their proclivity towards criminal behavior. Rather, it reflects the lack of a system to manage both felonies and petty crime committed by the mentally ill. Similarly, it demonstrates the U.S.'s current inability to effectively rehabilitate and reintegrate those seen in correctional facilities. For example, one of the ways the U.S. attempts to compensate for the lack of structure regarding the safety of those with mental illness is through what is colloquially known as “mercy bookings” (Lamb, Weinberger, & DeCuir, 2002). According to Brandt (2012), mercy bookings are arrests of mentally ill individuals for minor charges in order to protect them from victimization on the streets when they have no other options or community treatment available. However, these arrests have negative consequences and contribute to mentally ill individuals being arrested three to four times more than others without mental illness (Brandt, 2012). When a mentally ill individual is symptomatic, he or she may deface property, wander the streets and endanger themselves, engage in reckless drug use, or simply disturb the peace. All of these are grounds for arrest and detention (Brandt, 2012). While a few days in jail for these “crimes” may not be a problem for the general population, imprisonment can have devastating consequences for the mentally ill. The environment of a jail or prison is not conducive to rehabilitation or even stabilization, and so the inmates become increasingly symptomatic. As they continue to decompensate, they are detained for longer periods of time. In fact, mentally ill prisoners remain in prison an average of five months longer than those without mental illness (Brandt, 2012). The

longer they stay, the more symptomatic they become. The more symptomatic they become, the less safe they are to be released into the community. The less safe they are, the longer they stay. This cycle continues until correctional facilities get a court order to release them—often decompensated and without resources—back into the community. Often, correctional staff see them again in a few months, some even in a few weeks. This “revolving door phenomenon” is an indictment of the efficacy of the current system and practice. Clearly, something needs to change.

Current Practice

American Bar Association Standards

In order to begin changing the system, health care professionals must evaluate the efficacy of current practice. Though each state, and even county, runs its jails and prisons according to its own policies, there are still national standards of care that preside over each jurisdiction. These standards are outlined by the American Bar Association (ABA) and cover everything from acceptable forms of discipline to healthful foods. Part IV focuses on the required health care for inmates, making general requirements for the treatment of inmates with mental illness. The ABA mandates that those who have mental disabilities receive “special health care protocols” (23-6.1. a. iv; 2010) and be provided with “appropriate and individualized mental health care treatment and rehabilitation services...” (23-6.11. a; 2010). Similarly, any inmate who presents with signs and symptoms of mental illness should be “promptly referred to a qualified mental health professional for evaluation and treatment” (23-6.11. b; ABA, 2010). Furthermore, any inmate who is taking prescription drugs upon admittance to a jail or prison should be continued on those medications or treatment until a health care professional deems otherwise (23-6.5. b; ABA, 2010). The ABA also states that, “Prisoners diagnosed with severe mental illness should not be

housed in settings that may exacerbate their mental illness or suicide risk, particularly in settings involving sensory deprivation or isolation” (23-6.11. d; 2010). Unfortunately, many of these requirements are vague and interpretations vary according to each facility. Thus, implementation of these standards does not always have the intended effect and sometimes the standards are disregarded altogether.

Mental Health Screening

In order to follow ABA mandate 23-6.11. b, many correctional facilities implement mental health screenings upon intake (Brandt, 2012). These screenings are meant to identify those with mental illness in order to plan treatment and housing accordingly. In many facilities, this is accomplished through a questionnaire that asks about history of diagnosed mental illness, suicidal ideation, or undiagnosed manifestations of mental illness such as prolonged depression or hearing voices. If the inmate’s screen reveals that he or she has a diagnosed mental illness, or needs to be further evaluated for one based on the positive symptoms identified by the screening tool, then the correctional facility plans accordingly. This typically includes placing the inmate in the psychiatric unit, booking an appointment with the psychiatric team, and determining what psychotropic medications the inmate should either be prescribed or continue to take.

Evaluation of Mental Health Screening

The effectiveness of screening relies on the reliability and validity of the screening tool. According to Brandt (2012), the screening tools utilized by correctional facilities may not accurately assess mental illness. Brandt (2012) reports that even though the U.S. clearly has an influx of mentally ill inmates, the numbers of mentally ill inmates being admitted remained stable according to the screening tools. The discrepancy in numbers indicates that either the tool is not detecting mental illness appropriately or that the mentally ill inmate became symptomatic

once placed in the prison and jail environment (Brandt, 2012). Either way, the screening is ineffective in identifying mentally ill inmates, suggesting that those who need treatment for their mental illness are not receiving it. For example, Trestman, Ford, Zhang, and Wiesbrock (2007) conducted a study in Connecticut jails, examining the prevalence of mental illness amongst inmates who had not been identified as acutely mentally ill during the intake screening process. They found that among those who had been screened and determined not to be mentally ill, 69.7% met diagnostic criteria for a lifetime psychiatric disorder (Trestman et al., 2007). Furthermore, 21.2% of men had major depression, 37.6% of men had a lifetime anxiety disorder, and 20% of men had Post-Traumatic Stress Disorder (PTSD). The women fared worse with 49.3% of them meeting criteria for unipolar major depression, 26.4% meeting criteria for panic disorder, and 41.8% meeting criteria for PTSD. This is a significant percentage of men and women with varying mental illnesses that were missed by the screening process at intake.

Unfortunately, the U.S. has no standardized, well-researched mental health screening tool (Trestman et al., 2007). In a systematic review of research conducted on various tools, Martin, Colman, Simpson, and McKenzie (2013) concluded that while there were over 20 tools used throughout the nation, the most researched and commonly used ones were the Brief Jail Mental Health Screen (BJMHS), the Correctional Mental Health Screen for Men (CMHS-M), the Correctional Mental Health Screen for Women (CMHS-W), and the Jail Screening Assessment Tool (JSAT). Martin et al. (2013) concluded that while these tools have improved screening for mental illness in correctional facilities, further research needs to be conducted in order to address the contextual factors of implementing each tool.

The BJMHS, used frequently by jails to identify mentally ill individuals at intake, is well-received because it is quick and has thus far been assumed to be effective (Martin et al., 2013).

Steadman, Scott, Osher, Agnese, and Robbins (2005), however, conducted a study to determine the precision of the BJMHS in identifying inmates with mental illness and found that the accuracy of the tool may be questionable. After collecting data on 357 detainees in New York and Maryland jails, Steadman et al. (2005) found that while the tool correctly identified 73.5% of males with mental illness, it only detected 61.6% of females with mental illness. This is a significant number of women with mental illness who are missed with this screening tool. Unfortunately, this leads to an unnecessarily high number of women who are inappropriately placed and inadequately treated during their incarceration. In a subsequent study, Steadman, Robbins, Islam, and Osher (2007) examined the accuracy of a revised BJMHS which was designed to be more effective in identifying incarcerated females with mental illness. However, even this tool only identified 66% of women with mental illness at intake, which is not much of an improvement from the original screening tool (Steadman et al. 2007).

The CMHS-W shows more promise. Ford, Trestman, Wiesbrock, and Zhang (2009) conducted a study with 206 inmates to validate the CMHS-M and CMHS-W. They found that the CMHS-W accurately identified about 80% of women with mental illness (Ford et al., 2009), a vast improvement when compared to the BJMHS. However, while the CMHS-W tool increased accuracy in detecting women with mental illness overall, it had a high level of false positives amongst black women (Ford, Trestman, Wiesbrock, & Zhang, 2007). While having false positives may seem like a better option than missing individuals with mental illness, it can still be detrimental in correctional facilities where resources are limited. Correctional facilities unfortunately do not have the luxury of providing mental health care to everyone and therefore need to ensure that their resources are dedicated to those who are experiencing mental illness.

The JSAT is possibly the most accurate tool, but its usefulness is limited by its length. While the other tools take less than 5 minutes to administer, the JSAT takes approximately 20-30 minutes (Martin et al., 2013). Given the limited time, resources, and staff of correctional facilities, this tool is less likely to be implemented despite its higher accuracy rates.

While these tools all have their limitations and drawbacks, they also each have aspects that make them valuable. Hence, it may be beneficial to devise a new tool based on the positive aspects of each tool. After the tool is tested and retested for validity and reliability, it can be used as the standard across the nation to ensure that in every correctional facility, inmates with mental illness are accurately identified and appropriately treated.

Medication Administration

In most correctional facilities, medication is the most common form of treatment for inmates with mental illness (James & Glaze, 2006). As Adams and Ferrandino (2008) note, this is due partly to the lack of time, money, and other resources to implement anything else. Medication administration is one of the easiest method of providing mental health care and its use complies with ABA standard 23-6.5. a.

Evaluation of Medication Administration

Medication is a mainstay of mental health treatment. Medication reduces symptoms, decreases risk of harm to self or others, and helps prevent decompensation in an environment that already has a proclivity for exacerbating mental illness. However, despite the obvious benefits of pharmaceutical interventions and despite being the primary method of treating mental illness in correctional facilities, many inmates are not actually receiving the necessary treatment. In fact, according to Gonzalez and Connell (2014), of those who were admitted to prison with prescriptions for psychotropic medications, over 50% of them were not medicated while in

prison. This indicates that not only was continuity of psychotropic medication not prioritized, amongst half of the prisoners with prescriptions for psychotropic medications, it was non-existent. The Bureau of Justice similarly reports that of inmates with mental illness, only 27% of state prisoners, 19% of federal prisoners, and 15% of jail inmates received psychotropic medication during incarceration (James & Glaze, 2006). These numbers show that the majority of mentally ill inmates are not, in fact, being treated with appropriate medication. Furthermore, those who had mental illnesses that were less dramatically symptomatic, such as depression, were less likely to receive medication than those who had schizophrenia (Gonzalez & Connell, 2014). If the motive behind administering medication is simply to control the symptoms that are difficult for the corrections staff to handle, then those with negative symptoms (such as withdrawal, apathy, flat affect, or anhedonia) related to their mental illness will suffer. Medication should be available for all types of mental illness, not just the ones that are inconvenient for the criminal justice staff.

Psychiatric Department

Because the ABA mandates that mentally ill inmates receive “appropriate and individualized mental health care treatment” (23-6.11. a), many correctional facilities have an on-site psychiatric department. This department typically consists of psychiatrists, psychiatric nurses, case managers, and social workers. This psychiatric team is in place to provide the required adequate mental health treatment.

Evaluation of Psychiatric Department

While many correctional facilities have psychiatric staff available, care is not always provided consistently and within an adequate time frame. For example, at the King County Correctional Facility in Seattle, WA, psychiatric evaluations are to be completed within thirty

days of admittance (B. Balogh, personal communication, October 2017). By the time the inmate is seen, he or she may have already significantly deteriorated in status (Brandt, 2012). If inmates are not being seen until they have gotten worse or are acutely symptomatic, then the care being provided to these inmates does not align with nursing standards of health promotion and illness prevention. Nurses know that it is more effective to prevent health crises than it is to spend countless resources trying to treat them afterwards. Psychiatric treatment needs to begin before inmates decompensate in their cells.

Unfortunately, in some cases, treatment is not only delayed, it is absent. Brandt (2012) reports that less than half of mentally ill inmates actually receive treatment. If over half of mentally ill inmates are left untreated, then over half of mentally ill inmates are at an increased risk of prolonged jail stays. This, in turn, increases the risk that the mentally ill inmate may re-offend upon release and contribute to rising costs.

Furthermore, if the mentally ill inmates are being treated at all, the mental health care that they are receiving is questionable (Bewley & Morgan, 2011). In 2011, Bewley and Morgan found in their interviews of mental health service providers in state correctional facilities that 57% of them had not received specific correctional or forensics psychology training and that only 22.9% had ever completed a correctional psychology course. The problem here is that psychotherapy that does not address controlling criminal behavior may be ineffective in reducing criminality (Morgan, Kroner, & Mills, 2006). In order to reduce recidivism, the mental health service providers need to be targeting criminal tendencies in their sessions. If they are not trained to do so, however, they are not going to do so, rendering their treatment a waste of precious time and resources. Correctional facilities are already working with severely limited resources for mental health, so they cannot afford to implement wasteful treatment. This is especially true

when 65% of the interviewees reported dissatisfaction with the funding for rehabilitative services in correctional facilities (Bewley & Morgan, 2011). If correctional facilities are going to utilize resources to provide treatment, that treatment must be effective and financially responsible. The providers themselves seemed to recognize their own inefficacy, rating themselves as only neutrally or mildly effective (Bewley & Morgan, 2011). If even the ones who make up the psychiatric unit are rating themselves as only mildly effective at best, it is a good indicator that the system is not working as well as it should.

Administrative Segregation

Another practice employed by correctional facilities to care for mentally ill inmates is administrative segregation. Administrative segregation is used to remove an inmate from the rest of the inmates in order to either protect the inmate from self-inflicted injury, injury to others, or injury by others (Frost & Monteiro, 2016). The inmate is placed in a cell by himself or herself and has contact with the staff through the cell door and window. This type of housing goes by many names, not limited to isolation units, administrative maximum units, solitary confinement, secure housing, or supermax facilities. Though some variations exist between each system, they all essentially refer to a specialized unit or entire facility designed to hold inmates in single cells, 23-hours-per-day, for an indefinite time with minimal contact with others (Frost & Monteiro, 2016). This is done to maintain safety and security in the correctional facility (Frost & Monteiro, 2016). By placing mentally ill inmates in this environment, correctional staff are purportedly protecting them from inflicting or enduring harm. However, administrative segregation placement of the mentally ill goes directly against the ABA standards which state that “Prisoners diagnosed with severe mental illness should not be housed in settings that may exacerbate their mental illness or suicide risk, particularly in settings involving sensory deprivation or isolation”

(23-6.11. d). Nevertheless, mentally ill inmates continue to be overrepresented in administrative segregation.

Though some reports have indicated that only 1-3% of inmates are placed in administrative segregation, it is presumed that these numbers are underestimates due to facilities failing to report use of administrative segregation or under-reporting their use (Frost & Monteiro, 2016).

Though the exact rates are unknown, it is well documented that mentally ill inmates are overrepresented in administrative segregation placement (Adams & Ferrandino, 2008; Haney, 2018). In fact, Lovell (2008) found that in Washington supermax facilities, 45% of inmates had serious mental illness, psychological breakdowns, brain damage, or psychological symptoms. Beck (2015) reports that in U.S. prisons and jails included in the National Inmate Survey, 29% of prison inmates and 22% of jail inmates who were currently experiencing serious psychological distress had been placed in a restrictive unit within the past year. This is likely due to mentally ill inmates having difficulty following and conforming to the rules of the correctional facilities and thus incurring more numerous disciplinary actions taken against them for misconduct which lands them in administrative segregation (Frost & Monteiro, 2016).

Evaluation of Administrative Segregation

While administrative segregation's main purpose is safety and protection, it continues to have negative consequences, especially for those with mental illness (Haney, 2018). Numerous studies show that placing anyone in isolation results in varying degrees of mental instability (Haney, 2018). So to place one who is already mentally unstable in an environment that induces deterioration of mental status is counterproductive. When a mentally ill inmate emerges from administrative segregation placement, he or she experiences both psychological and psychosocial disturbances, including increased anxiety or lethargy, cognitive issues, lack of control, irrational

anger, nervous breakdowns, and social withdrawal (Brandt, 2012). Administrative segregation is not a fitting placement for those who are mentally ill. While reducing stimuli is beneficial for those who are experiencing mania, depriving them of human contact is not an evidenced-based practice. Similarly, placing a depressed and suicidal inmate in a room with no positive stimulation is simply going to plummet them further into their depressive state. It may be necessary to have solitary rooms for de-escalation purposes, but it is never appropriate to place an inmate with mental illness in prolonged solitary confinement. This simply exacerbates symptoms and amplifies deterioration.

While administrative segregation is supposedly utilized to protect the inmate, other inmates, and staff from harm, it can actually increase the risk of harm to the inmate, particularly by increasing the risk of self-harm and suicide. Many inmates see administrative segregation as a punishment (Brandt, 2012). While in some cases it is a punishment, in other cases, such as suicide prevention, it is meant to protect the inmate. Nevertheless, when inmates are placed in administrative segregation, they are deprived of meaningful human contact, any sort of positive stimulation or entertainment, and in the case of suicide precaution, even clothing. It is not hard to see why they may interpret their situation as a punishment. Thus, in order to avoid being placed in administrative segregation, many inmates hide their suicidal thoughts and behaviors (Adams & Ferrandino, 2008). This in turn leads to increased risk of suicide (Adams & Ferrandino, 2008). Furthermore, self-harm is prevalent in administrative segregation placement as well. Kaba et al. (2014) examined the rates of self-harm in New York City jails. They reported 2182 acts of self-harm amongst 1303 inmates, with 103 being potentially fatal and seven being fatal. Only 7.3% of the 1303 inmates were in solitary confinement, and yet, 53.3% of acts of self-harm as well as 45% of acts of potentially fatal self-harm occurred within the solitary confinement group (Kaba

et al., 2014). It is evident that solitary confinement is not truly effective in protecting inmates from self-harm.

Finally, administrative segregation is simply fiscally irresponsible. The U.S Government Accountability Office estimates that the cost of securing 1,987 inmates in federal "special management units" was \$87 million. If those inmates had been housed in medium-security facilities, the cost would have been cut in half at \$42 million. Even if they had been housed in high-security facilities, the cost would only be \$50 million (Frost & Monteiro, 2016). Similarly, when Colorado decreased the number of inmates in solitary confinement by 36.9%, the state was projected to save \$4.5 million that year and \$13 million the following year (Steinbuch, 2014). This is attributable to the fact that with decreased administrative segregation placement, there is less staff needed for repeated searches, continuous checks, or two-on-one escorting (Steinbuch, 2014). Essentially, by decreasing solitary confinement, Colorado decreased costs.

Co-occurring Disorders

The treatment currently available does not often consider co-occurring disorders (Brandt, 2012). The most prevalent co-occurring disorder amongst mentally ill inmates is substance abuse (Brandt, 2012). The Bureau of Justice reports that 74% of mentally ill prisoners and 76% of mentally ill jail inmates had co-occurring substance abuse or dependence (James & Glaze, 2006). If only the mental illness is treated while the substance abuse is ignored, then the inmate is unlikely to improve in the long run, leading to re-arrest in the future (Brandt, 2012).

Drake, Mueser, Brunette, & McHugo (2004) reviewed 26 studies on treating co-occurring disorders in order to find the best strategies for treating what is known as a "dual diagnosis." In all these studies, they found that the most effective strategy is integrated treatment (Drake et al., 2004). This means not only that both mental illness and substance abuse are treated, but that they

are treated *together*. By making them integrated rather than parallel, this treatment method recognizes that these two disorders are intertwined and treats them as such. Furthermore, when the disorders are tackled together, it decreases the complexity of treatment from the inmate's perspective, thereby decreasing the likelihood that the inmate gets overwhelmed, gives up, and drops out. By ensuring a cohesive program with minimal negotiating with multiple care systems, nurses increase the likelihood that the inmates will comply with the treatments (Drake et al., 2004).

Weiss et al. (2007) found similar results regarding integrated treatment. In a randomized control trial comparing integrated group therapy to isolated drug therapy amongst patients with substance abuse disorder and bipolar disorder, they found that during treatment, the integrated treatment group used drugs and alcohol fewer days per month than the control group. In fact, substance use amongst the control group was 10 days per month while those who were in the integrated treatment group used only 5.3 days per month (Weiss et al., 2007). This is half as many days as the control group showing vast improvement in the integrated treatment group. This success continued when they followed-up after completion of the treatment program. While the control group used 12 days per month, those in the integrated treatment group only used an average of six days (Weiss et al., 2007). Integrated therapy is a promising way to treat co-occurring disorders while maintaining patient engagement and participation. Furthermore, in correctional facilities where staff is limited, it is more feasible to treat two disorders at one time than try to treat them at separate time with separate people and separate resources.

Evaluation of General Effectiveness of Current Practice

Having examined the specific efficacy of current practice, it is important for the current practice to be evaluated for effectiveness from a wider perspective as well. Nurses require this

information to perform their duties, for evidence-based care is foundational to nursing practice and medicine. Thus, in the context of caring for mentally ill inmates, nurses must know if the care they are providing is the most effective method of treatment for the individual. Evaluation is a necessary step in the process of ensuring appropriate care for the target population. In this setting, effectiveness is measurable by recidivism as well as prevalence of use of force.

Recidivism

The first category that highlights the success of interventions on behalf of mentally ill inmates is recidivism. Recidivism of mentally ill inmates provides information regarding effectiveness for it shows if medical interventions provided in the jails and prisons effectively help inmates reenter society and consequently reduce re-arrest after release. Unfortunately, with the current treatment, recidivism amongst those with mental illness are often higher than those without. In Connecticut, 16, 241 inmates were followed for three years after their release in 2005. Of these, 766 were given an MH5 level and 748 were given an MH4. These levels are an indication of mental health treatment requirements. An MH5 category is reserved for inmates with a crisis level mental disorder and indicates a need for twenty-four-hour nursing care while an MH4 category refers to inmates who have a mental illness severe enough for specialized housing and psychiatric treatment. After following the data of the inmates for three years, both the MH5 and MH4 groups were found to have had “significantly higher recidivism rates than the cohort average” (Office of Policy and Management, 2010). The cohort as a whole had poor results to begin with. Of the 16, 241 total inmates, 67.5% were rearrested, 56.5% were committed with new charges, and 36.6% were reincarcerated to serve a new sentence (Office of Policy and Management, 2010). Though these numbers are quite high, they still represent the

general inmate population. The inmates with psychiatric illness had significantly higher recidivism rates.

In a 2009 study of 116 correctional facilities in Texas, Baillargeon et al. concluded similar results. They examined the records of 79, 211 inmates for data on psychiatric disorders and history of incarcerations in the last six years. Of the total sample, 7,878 inmates were diagnosed with one of four major mental illnesses. These were major depressive disorder, bipolar disorder, schizophrenia, and nonschizophrenic psychotic disorders. They found that compared to their non-mentally ill counterparts, inmates with mental illness had “substantially increased risk of multiple incarcerations over the 6-year study period” (Baillargeon et al., 2009). Furthermore, inmates diagnosed with bipolar disorder were 3.3 times more likely to have at least four previous incarcerations in that timeframe (Baillargeon et al., 2009).

In 2006, the Bureau of Justice collected data regarding inmates with mental illness in the U.S. They found that of those who had mental illness, nearly 25% of them had already been incarcerated at least three times previously (James & Glaze, 2006). Similarly, in a study conducted in California, it was found that those most likely to return to custody within a year of release were those with a diagnosed mental health disorder. Compared to the 29.7% of the general population who were returned to custody, 52.8% of inmates with a mental health disorder were returned to custody within one year (Louden & Skeem, 2011). This indicates that recidivism rates among those with mental illnesses are higher than those of inmates without mental illness. The current treatment provided in the jails and prisons for mental illness is clearly ineffective in reducing recidivism rates among those with mental illness.

Use of force

The second category to examine is the use of force by the corrections officers. If guards are using high levels of force during interactions with mentally ill inmates, it can indicate two things. First, it indicates that the mentally ill inmate remains in an acutely symptomatic state in which they are unable to follow the guards' commands and unable to comprehend verbal threats. Because of this, the guards then employ force to elicit an obedient response. Secondly, high levels of use of force demonstrate the guards' lack of knowledge. While force is sometimes unavoidable, many times it can be circumscribed if the enforcer understands the circumstances of the situation (Adams & Ferrandino, 2008). If officers were more aware of the cognitive incapacities that many inmates experience with mental illness, they may be slower to implement the use of force (Adams & Ferrandino, 2008). Similarly, if they were educated regarding alternative de-escalation and redirecting techniques, guards would decreasingly feel the need to resort to force.

Interventions

After evaluation of current practice, it is clear that improvements must be made if treatment is to meet nursing standards of providing holistic, effective, evidence-based care. So what interventions can be implemented to improve the care of inmates with mental illness? There are many alternative options that are showing promising results. Guided by these results, nurses can work to implement evidence-based practice and improve the efficacy of treatment.

Therapy

One particularly effective intervention is therapy. As previously mentioned, medication, though it is not administered consistently, is the current practice in jails and prisons for treating mental illness. However, though this is absolutely necessary, psychotropic medication without psychotherapy is inadequate treatment for a mentally ill patient (Brandt, 2012). Kay Redfield

Jamison (1995), writing about her struggles with bipolar disorder, states, “Lithium prevents my seductive but disastrous highs...keeps me out of the hospital, alive...But, ineffably, psychotherapy *heals*” (p. 88). In her experience, therapy must accompany medication to achieve effective treatment of her mental illness.

There are, however, many types of therapies. In a study comparing the effects of interventions on young offenders, Lipsey (as cited in Clark, 2010) found that punishment and deterrence based interventions actually tended to increase recidivism. In contrast, Lipsey (as cited in Clark, 2010) concluded that more therapeutic methods which incorporated skill-development and counseling were most effective in reducing recidivism.

Cognitive behavioral therapy. One such type of therapy that has been shown to be effective is Cognitive Behavioral Therapy (CBT). In fact, Lipsey (as cited in Clark, 2010) found that CBT was the most effective intervention in reducing criminal behavior, including in high-risk offenders. This is possibly attributable to the “self-help” nature of CBT which encourages participation and allows inmates to be more “in charge” of their own treatment while simultaneously giving them the techniques and skills to do so successfully (Clark, 2010). While this study confirms the effectiveness of CBT amongst inmates not specified to be mentally ill, numerous studies show that CBT is also efficacious for inmates with mental health issues.

In a randomized controlled pilot study, Zlotnick, Johnson, and Najavits (2009) evaluated the effectiveness of CBT in 49 incarcerated women with post-traumatic stress disorder (PTSD) and substance use disorder. The particular program used to implement CBT was called Seeking Safety. This program is defined as “psychoeducation and the development of coping skills to help clients attain safety from both PTSD and SUD [substance use disorder]; it is present-focused, abstinence oriented, and emphasizes an empowering, compassionate approach”

(Zlotnick et al., 2009). Zlotnick et al. (2009) found that, when compared to treatment as usual, those who participated in the Seeking Safety program had greater improvements in psychopathology at both three and six months. The greater number of CBT sessions attended was correlated with greater improvement of PTSD symptoms and drug use. Furthermore, those who participated in CBT improved in PTSD symptoms as rated by clinicians. Finally, those who only received treatment as usual worsened in self-reported PTSD symptoms (Zlotnick et al., 2009).

CBT has been shown to be most effective when it incorporates homework (Morgan, Flora, Kroner, Mills, Varghese, & Steffan, 2012). Homework is essentially the practice of a new skill or behavior, often with a component of social interaction (Morgan et al., 2012). The goal is to “over-learn” information and then practice implementation of that information into the real world (Morgan et al., 2012). In a research synthesis evaluating efficacy of treatment based on eight outcomes, Morgan et al. (2012) found that programs that incorporated homework into the treatment of mentally ill inmates were correlated with stronger positive outcomes than those that did not. In general, Morgan et al. (2012) found that treatment produced strong positive outcomes for mental health symptoms and coping. However, homework itself tended to produce strong positive outcomes in all eight categories, including mental health symptoms, coping, institutional adjustment, behavioral functioning, criminal and psychiatric recidivism, treatment-related factors, and financial benefits (Morgan et al., 2012). Thus, in order to help mentally ill inmates learn and practice new skills and behaviors until they become more natural or even automatic, correctional programs should implement active homework into their treatment of mentally ill inmates.

A program that has already been created and incorporates CBT is the Illness Management and Recovery (IMR) program (MacKain & Mueser, 2009). This program, created by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Robert Wood Johnson Foundation, focuses on self-management of mental illness using strategies such as education, motivation, and CBT (MacKain & Mueser, 2009). The IMR is based on five evidence-based practices, such as “psychoeducation, behavioral tailoring for medication adherence, relapse prevention training, social skills training for social support, and teaching coping skills for persistent symptoms” (MacKain & Mueser, 2009). After completing the ten modules of the program, participants have been shown to improve in coping with symptoms, to make progress toward both personal and recovery goals determined at the onset of the program, and to increase in knowledge (MacKain & Mueser, 2009). This program is not only free to implement, it is also available online (MacKain & Mueser, 2009). Due to its accessibility, low cost, efficacy, and foundation in evidence-based practices, this is an optimal program to utilize amongst mentally ill inmates.

Group therapy. Another type of therapy shown to be particularly effective in the criminal justice system is group therapy. Group therapy is an ideal method of delivering mental health treatment within the criminal justice system because of the disproportionate ratio of mentally ill inmates to mental health staff in jails and prisons (Morgan, Kroner, & Mills, 2006).

Morgan, Kroner, and Mills (2006) recognize the complex nature of integrating group therapy in the criminal justice environment. Consequently, they suggested multiple strategies to improve the efficacy of group therapy in the jail and prison systems. First, each component of therapy should be simple and achievable (Morgan, Kroner, & Mills, 2006). Because inmates who fail at tasks will be unlikely to continue participating in a program, it is essential that the therapy

be easy to understand and simple to apply. Second, as mentioned with the utilization of homework, the inmates should be saturated in the new behaviors and essentially “over-learn” the information in order to override their default behavioral patterns until the new patterns of behavior become natural and automatic (Morgan, Kroner, & Mills, 2006). This strategy, when accomplished through homework, forces the inmate to take what is learned during group therapy out into their “real world,” thereby making it applicable and natural in a larger context (Morgan, Kroner, & Mills, 2006). Thirdly, the therapist should use the group therapy time to target criminal behavior. Essentially, the objectives and exercises of the therapy sessions must be relevant to the reduction of criminal behavior (Morgan, Kroner, & Mills, 2006). If the goals are vague and unrelated, the therapy will not only be ineffective in reducing re-arrest and recidivism but it may also lead to an inmate with an inflated self-esteem without an understanding of how to reduce criminal behavior (Morgan, Kroner, & Mills, 2006). Then, the inmate still ends up a repeat offender, but now he feels good about himself. By targeting criminal behavior, the group therapy sessions can more effectively reduce the likelihood of recidivism. All these strategies can help increase the effectiveness of group therapy time while reducing the inherent complications associated with group therapy.

The successes of various forms of therapy programs means that evidence-based practice demands the use of therapy in conjunction with medication, not simply medication alone. To provide inmates with holistic, effective treatment, jails and prisons must incorporate consistent therapy in treatment regimens. Thus, therapy must be part of the treatment provided in all correctional facilities.

Decrease Administrative Segregation

As previously indicated, the use of administrative segregation has been shown to be

particularly harmful to mentally ill inmates. Furthermore, those who are placed in administrative segregation are actually more likely to reoffend than inmates who are not (Brandt, 2012). Thus, an intervention to enhance the care of mentally ill inmates while bettering outcomes is to decrease administrative segregation placement.

Though some may fear decreasing administrative segregation will compromise safety and security, the evidence does not support this. In fact, in 2011, correctional facilities in Maine significantly decreased their use of solitary confinement (Heiden, 2013). One facility closed a pod of solitary confinement units and decreased its solitary confinement placements by half in 18 months. Despite utilizing solitary confinement less, the facility has not experienced a significant increase in violence, and in fact reported that by some measures, incidence of violence has decreased. Maine, now viewing administrative segregation as a last resort, has successfully decreased administrative segregation usage without compromising safety (Heiden, 2013).

Maine is not the only state making great strides in reducing administrative segregation placement while proving that doing so is effective. In Mississippi, the correctional staff at Unit 32 worked to decrease rates of administrative segregation by rewriting the criteria for placement in administrative segregation (Kupers et al., 2009). After redoing this, they found that 80% of the administrative segregation population did not meet the criteria. Thus, Unit 32 dropped from 1000 prisoners in administrative segregation to only 150. In order to make the transition from administrative segregation to the general population as smooth as possible, Unit 32 implemented a step-down unit and program. Through decreasing administrative segregation and providing a safe transition, Unit 32 vastly decreased the need for use of force by guards. In fact, they found that following the changes, serious incidences between inmates and between inmates and staff dropped by 70%. The significant drop in serious incidences shows that decreasing administrative

segregation does not, in fact, lead to increased violence. Furthermore, the decrease in administrative segregation proved specifically beneficial for inmates with serious mental illness. As earlier reported, inmates with mental illness often have greater numbers of rule violation charges against them. Before decreasing administrative segregation and implementing the step-down program, mentally ill inmates as a group received 253 rule violations in a month, averaging about 4.7 rule violations per mentally ill inmate. Once the program began, the group of inmates with serious mental illnesses decreased the number of rule violations to 50, or about 1.2 per inmate. Six months afterwards, these rates continued to decline with mentally ill inmates receiving only 30 rule violations, which is only 0.6 rule violations per person (Kupers et al., 2009). Clearly, decreasing administrative segregation and creating a transitional program can drastically decrease behavioral issues amongst mentally ill inmates and improve their mental health.

Reintegration Programs

Another method to reduce recidivism and improve mental health care for inmates is through reintegration programs. These programs help transition inmates back into society and bridge the gap between correctional living and community living. The two biggest challenges faced by inmates reentering society are affordable housing and stable employment (Baillargeon, Hoge, & Penn, 2010). These challenges are amplified in mentally ill inmates who are more likely to experience homelessness during reentry (Mallik-Kane & Visher, 2008). These individuals are also far less likely to find employment. Mallik-Kane and Visher (2008) found that while 53% of male inmates in the general population found legal employment, only 28% of mentally ill male inmates were able to do so. Similarly, only 18% of female mentally ill inmates found legal employment while 35% of their non-mentally ill counterparts did (Mallik-Kane & Visher, 2008).

It is clear that mentally ill inmates have a more difficult time reentering society. This is likely because treatment programs and discharge planning available in most correctional facilities is inadequate (Baillargeon et al., 2010). As Baillargeon et al. (2010) point out, correctional facilities need to do more than hand out a two-week supply of meds and a list of mental health clinics in the area. For many mentally ill inmates, this information is of little value for they have no health insurance. When mentally ill individuals are incarcerated, their public assistance and government benefits are stopped and do not automatically resume upon release (Hoge, 2007). Not only is the bureaucracy involved in reinstating those benefits difficult to navigate, it can also take 45-90 days to process (Hoge, 2007). This is a long time to go without treatment, which may contribute to the failure of many mentally ill inmates to successfully reenter society. In fact, in a study conducted in Washington state, Lovell, Gaglia, & Peterson (2002) found that of 337 mentally ill inmates followed for one year after release, only 16% were receiving steady mental health treatment and 41% were rearrested. These numbers indicate why it is essential that prior to release, adequate discharge planning be established and mentally ill inmates be equipped with the resources they need to succeed.

Reentry success can be accomplished through reintegration programs. For example, in California, the Board of Corrections offered grants to correctional facilities to implement and study the effect of transitional programs for mentally ill inmates (as cited in Hoge, 2007). Each facility randomly assigned mentally ill inmates to either the control group receiving treatment as usual or the experimental group which received the transitional programs. A total of 4,700 plus inmates were followed for two years. Researchers found that between the control group and the experimental group, the experimental group had better outcomes at two years. For instance, only 30% of the experimental group were economically insufficient while 53% of the control group

were economically insufficient. Likewise, only 7% of the experimental group were homeless while 12% of the control group were homeless. Compared to 55% of the control group, 45% of the experimental group experienced drug abuse. Similarly, compared to 49% of the control group, only 38% of the experimental group had alcohol problems. Finally, while 32% of the control group had worsened in functionality, only 21% of the experimental group had done so (as cited in Hoge, 2007). These transitional programs helped decrease numerous poor outcomes associated with mentally ill inmate reentry.

Training and Collaborating with Officers

Because mentally ill patients are infiltrating correctional facilities, they are consistently encountering correctional officers. This can create tension as the officer chooses between safety and care. Thus, an intervention that can be implemented to reduce the cognitive dissonance and subsequent use of force by the officers is simply training the officers about mental illness, how it manifests, and ways to deescalate and encourage obedience without resorting to force. Simply training the correctional staff about mental illness is one of the most effective interventions available in jails and prisons (Brandt, 2012). By collaborating with the guards, the health care team can significantly reduce the trauma mentally ill inmates undergo while in the criminal justice system.

Providing trauma-informed care is an expectation of staff in hospitals, but it seems to be an exception in the criminal justice system. Though the prison and jail environment is anything but conducive to minimizing trauma, staff should do their utmost to provide trauma-informed correctional care (TICC). Miller and Najavits (2012) explain that TICC enhances the effectiveness of other therapies, particularly CBT. Essentially, if the trauma is unaddressed or worsened, then the inmate is unlikely to participate in the CBT (Miller & Najavits, 2012). By

implementing TICC, the correctional staff can help minimize destabilization related to triggers and thereby reduce the need for force, restraints, or seclusion (Miller & Najavits, 2012).

However, correctional officers may perceive TICC as risky when, in fact, the opposite is true (Miller & Najavits, 2012). Miller and Najavits (2012) note that implementing punishments or authoritative measures without treating the mental illness is one of the least effective ways of controlling criminal behavior. It is, then, safer to utilize TICC than it is to forgo it. By minimizing triggers, correctional staff can minimize associated destructive behaviors from mentally ill inmates and increase the security and stability of the jail or prison environment.

Unfortunately, correctional officers may be hesitant to adopt TICC, seeing it as weak or “pandering” (Miller & Najavits, 2012). This is why training is essential. If the correctional officers do not understand why TICC is important, how it helps, or how to effectively implement it, they are not going to do it. Miller and Najavits (2012) suggest collaborating with senior officers to train the correctional staff. If they learn from someone they already find credible and who knows what their job is like, the correctional officers are more likely to trust the information being taught and more willing to try new interventions (Miller & Najavits, 2012).

Furthermore, prison and jail wardens tend to believe that administrative segregation is an effective method of reducing violence within correctional facilities. Mears and Castro (2006) conducted a survey to elicit wardens’ perspectives on supermax prisons and found that they almost unanimously agreed that supermax prisons decreased violence while increasing safety, order, and control. However, Sundt, Castellano, and Briggs found that those who support administrative segregation and supermax prison usage tend to do so based on their own experience, rather than evidence-based practices (as cited in Frost & Monteiro, 2016). In order to

change this prevailing assumption, correctional officers must be informed and educated on the effects of administrative segregation.

Reasons to Change

These are effective measures for treating the growing population of mentally ill inmates. But perhaps the question lingers, why should we? There are three main reasons to improve treatment for this population. First, correctional facilities are not currently suitable for mental health treatment. Second, doing so will decrease recidivism and associated costs. Third, these people are human beings who deserve to be treated as such.

Correctional Environment

To elaborate on the first point, care for the mentally ill in the criminal justice system needs to be a focus because correctional facilities are not places mentally ill individuals *should* be treated, but this is where they *are* treated. Though jails and prisons have become the de facto mental institutions of our era, they were never set up to be. Thus, they are ill-equipped to treat any inmate with mental illness, let alone the high volumes they are currently experiencing. The inability of correctional facilities to provide adequate mental health treatment stems from many reasons, but perhaps the most obvious is the conflict of interest between the purpose of a jail or prison and the goals of those caring for mentally ill inmates. As Brandt (2012) points out, correctional staff, who focus on safety and security, and mental health professionals, who treat and diagnose, have conflicting roles. Because a guard's modus operandi is to ensure order and safety through punishment while a health care professional works to rehabilitate, the two inevitably clash. When corrections officers believe they are faced with two choices—safety or treatment—they will elect to uphold the duty they perceive as a priority given their role and thus

choose safety. Unless they are trained otherwise, when the clash occurs, psychiatric rehabilitation will lose (Adams & Ferrandino, 2008)

It follows then that the firm rules imposed by correctional facilities make them unfit to house mentally ill individuals. Mentally ill inmates cannot follow the strict, militaristic rules of correctional facilities and thus incur extra punishment or administrative segregation for their perceived “disobedience.” An inmate, already confused and overstimulated, is not going to understand the orders being barked at him from an officer (Brandt, 2012). An inmate, paranoid and convinced that the guards want to kill her, is not going to obey that same guard whom she is genuinely afraid of. An inmate, depressed and immobile, is not going to cognitively comprehend and respond to an order with the speed which is expected of him. Failure to comply with the rules earn the mentally ill inmates punishments that are meted out perhaps justly to the general population, but which are inappropriate for this one. Brandt (2012) reports that the Colorado Department of Corrections found that mentally ill inmates had higher rates of disciplinary action taken against them for in-facility offences than did the rest of the general population; because of this, they were increasingly likely to be placed in administrative segregation. Similarly, the Bureau of Justice reports higher rates of charges for rule violations amongst mentally ill inmates compared to the general population (James & Glaze, 2006). In state prisons, 58% of mentally ill inmates were charged with rule violations compared to 43% of general population inmates. Similarly, in federal prisons, 24% of mentally ill inmates were charged with rule violations compared to 14% of the general population. The trend continues in jails with 19% of mentally ill inmates receiving charges compared to 9% (James & Glaze, 2006). Clearly, mentally ill inmates are being charged with rule violations at greater rates than their non-mentally ill counterparts. Brandt (2012) explains that inmates experiencing depression, psychosis, paranoia, and

hallucinations have more violent and nonviolent rule violations. These rule violations and acts of impulsivity, however, are rarely intentional amongst mentally ill inmates. In fact, among inmates with mental illness, 66% of them had a reactive rather than a criminal thought process (Brandt, 2012). This means that they react to their environment with hostility and emotionality but have no intentions or goals to be disruptive (Brandt, 2012). Thus, punishing an expression of their illness is not justifiable.

Furthermore, jails and prisons are not conducive to mental stability. In fact, correctional facilities are detrimental to even those without a history of mental illness. Brandt (2012) reports that in 2006, a survey was conducted in both jails and state and federal prisons which found that 40% of jail inmates and 30% of prison inmates who had no history of mental illness began having symptoms of mental illness. This indicates that the prison and jail environment is so bad for mental health that even those without previous psychiatric issues started displaying symptoms. Furthermore, the environment and inadequate care can lead to increased suicide, recidivism, and exacerbation of the inmate's mental illness, causing lasting psychological damage and rendering it difficult for inmates to successfully reintegrate themselves back into the community (Brandt, 2012). Because correctional facilities are currently ill-suited to house mentally ill inmates and they are, in fact, detrimental to mental health, it is imperative that nurses work to improve the correctional environment and the treatment mentally ill inmates receive.

Decreased Recidivism Rates

The second reason to focus on improving the care of mentally ill inmates is because doing so can reduce recidivism and associated costs. In Connecticut, data was collected on 883 inmates regarding recidivism. The study examined two different approaches to treating the mentally ill both during and after their imprisonment. With the standard policy (DMHAS), recidivism rates

were 28.3% in the first six months. With the newer system, the Connecticut Offender Reentry Program (CORP), recidivism rates were only 14.1%. The main difference is that CORP emphasizes training that will help offenders reenter civilian life at a functional level. Thus, they have group therapy, trainings on life skills and coping mechanisms, teaching on medications and warning signs related to their mental illness, aid with housing, and continued contact until a provider is established for the recently released inmate (Kesten et al., 2011). By simply providing adequate treatment during the inmate's stay, the facility cut recidivism rates in half. This is a significant improvement and bolsters the argument that appropriate treatment is necessary and effective.

If correctional facilities can reduce recidivism, they can reduce overall costs. One reason some are opposed to implementing more interventions on behalf of mentally ill inmates is simply because correctional facilities do not have the financial resources available to do so. Proponents of this claim may agree that it would be nice to treat mentally ill inmates as this paper proposes, but it is simply not feasible. Therapy programs, adequate psychiatric staffing, training for correctional staff, rehabilitation and reentry programs—these are costly to implement. So, who is going to pay for these criminals to get treatment? However, through financial analysis, it is apparent that it is more cost-effective to provide treatment and thereby prevent decompensation and associated recidivism.

In response to the financial argument, recidivism is costlier in the long run than effectively treating inmates the first time. This recidivism is often referred to as the revolving door phenomenon which describes the constant readmittance of inmates after they have been released. This trend is disproportionately high amongst inmates with mental illness. Unfortunately, a common occurrence is for a mentally ill individual to be arrested, receive inadequate mental

health treatment in the jail or prison systems, be released, and be re-arrested. Rather than providing effective mental health treatment to the inmates and helping them stay out of the criminal justice system, the U.S. system releases and re-arrests them, starting the cycle all over again. This revolving door phenomenon, however, is costly. In a study conducted in Florida, Van Dorn, Desmarais, Petrila, Haynes, and Singh (2013) found that the cost of care for mentally ill inmates was significantly greater than the cost of care for non-arrested mentally ill individuals, even when including the cost of more outpatient services utilized by mentally ill patients not involved in the criminal justice system. In their sample, 1,263 participants were involved in the criminal justice system. These 1,263 participants were 31% of the whole sample, leaving 69% of the participants who were not involved in the criminal justice system. Once total costs from 2005 to 2012 were calculated (including acute care, emergency mental health services, outpatient care, criminal justice care, and psychiatric hospitalization), Van Dorn et al. (2013) found that the 31% alone cost an average of $\$94,771 \pm \$106,890$ in the seven year time frame whereas those who were not in the criminal justice system cost only an average of $\$68,348 \pm \$100,700$.

Furthermore, Van Dorn et al. (2013) found that even when they did not include the costs of the justice system, those who were involved in the criminal justice system still had significantly higher treatment costs. Clearly, it is more cost-effective to keep mentally ill individuals out of the criminal justice system than it is to repeatedly care for them within the confines of the jails or prisons. If correctional facilities can reduce decompensation in the criminal justice system, adequately provide mental health treatment, and foster an environment that is conducive for recovery, then they can reduce recidivism and thereby reduce costs.

Human Beings

Finally, nurses who are Christian must advocate for change in the treatment of mentally ill inmates because these inmates are human beings made in the image of God. Christian nurses must be willing to care for even the criminals. In his book, *Mountains Beyond Mountains*, Tracy Kidder details Paul Farmer's work on behalf of Russian prisoners. Kidder (2003) comments, "Prisoners were part of PIH's [Partners in Health] special constituency—the Gospels said so; you could look it up, in Matthew 25" (p. 221). This is the second time Kidder references Matthew 25 and the verse perfectly describes what being Christian entails. Being Christian means serving the hungry, the poor, the criminal, the broken, just as one would serve Christ. It is clear that Christians are explicitly called by Christ to serve prisoners, and because of this, it is both a nurse's duty and privilege to serve incarcerated individuals.

Christians are constantly striving to be like Christ. To be Christ-like, Christian nurses must learn to love as he does—that is, unconditionally. Regardless of their poverty or their crime, the very patients that nurses are serving are the ones Christ loves and died for. In fact, truly understanding Christ's work leaves no excuse to dismiss the plight of the vulnerable. George Marsden (1997), author of *The Outrageous Idea of Christian Scholarship*, points out:

In the incarnation, Christ emptied himself and became poor for our sake. He identified with the poor and the ordinary. Christ went so far as to instruct us that when we see the poor and the destitute, we see him. How we act toward them is an indicator of how we love him. (p. 93)

A Christian nurse's claim to Christianity, claim to loving Christ, is only substantiated if they also love and serve others, particularly the despised. Marsden (1997) writes, "God's display of his sacrificial love to us in Christ relativizes our self-righteousness. United with Christ, we are to love even those whom we would naturally despise" (p. 93). Thus, to truly be followers of Christ,

Christian nurses must be willing to serve the poor, the miserable, and the vulnerable.

Incarcerated mentally ill inmates absolutely fit this category.

Furthermore, the nursing profession itself is guided by a code of ethics. This code guides the nurse's decisions and moral quandaries. Nurses are bound by this code and must adhere to its provisions. The very first provision states that "The nurse, in all professional relationships, practices with compassion and the recognition of human dignity and worth that is present in every individual" (American Nurses Association, 2015). Every individual, even the criminalized individual, must be treated with dignity and compassion. These inmates have been stripped of everything. Their lives, comforts, families (if they had them), friends, homes, privacy, dignity; everything is taken away in the jails and prisons. The only thing they have left is their humanity, and even their hold on that is threatened in the jail. It is the nurse's job to remind them through his or her care that they are human beings who deserve respect. Mentally ill inmates, despite their diagnoses and their crime, are still human and should be treated as such. No human being deserves to continually suffer from their mental illness. They deserve the most effective treatment available. These patients cannot advocate for themselves; they are inmates, they are mentally ill, they are looked upon by many as the lowest of the low. It is the job of nurses to advocate for the voiceless and the vulnerable.

Refutation Points

The Punishment Imperative

Some may contend that the argument on behalf of mentally ill inmates is invalidated by the purpose of the criminal justice system. The criminal justice system, they would say, is a punitive system and not a restorative one. These incarcerated individuals are, after all, criminals who

deserve to be punished, not given special treatment and rehabilitation. As Brandt (2012) notes, U.S. society focuses not on rehabilitating inmates but on punishing them.

There are three responses to this argument. First, in the U.S., many of the mentally ill are incarcerated for petty crime and manifestations of their mental illness. If inmates must be punished for their crimes by not receiving treatment, then the U.S criminal justice system only promotes their potential to commit even more crimes. No one out-rightly states that mental illness is a crime, but at the rate at which the mentally ill are incarcerated, it appears that mental illness is punishable by law. When these individuals are incarcerated for petty crime and then fail to receive adequate treatment in jail, they decompensate. This only prolongs their incarceration, worsening their condition and leading to longer sentences. If mental illness is not a crime, why does the U.S. treat it as such?

Secondly, for those inmates who are incarcerated for felonies, allowing them to suffer mental illness is a punishment that does not fit the crime. The eighth amendment prohibits the use of cruel and unusual punishment. Using a person's own mental illness to punish him or her is cruel and unusual. Deep depression, crippling anxiety, frantic paranoia, confused mania, dangerous grandiosity, disturbing hallucinations—these are punishments that correctional staff would not be legally allowed to inflict on criminals even if they could. So how is it appropriate to allow mentally ill inmates to suffer these symptoms in the name of punishment? Nurses must advocate for just and equitable treatment for all individuals, regardless of their legal, financial, or social status. This means that nurses cannot allow mentally ill inmates to remain untreated or undergo punishments that are far too severe for any crime. In the *Code of Ethics for Nurses*, Provision 9 demands that nurses “integrate principles of social justice into nursing and health

policy” (American Nurses Association, 2015). Thus, it is absolutely the nurses job to fight for the implementation of just treatment for mentally ill inmates.

Finally, nurses in the U.S must question the very premise that the sole purpose of correctional facilities is to dole out punishment. While it is true that this is the most prevalent reason for their existence, nurses must consider other perspectives on what justice entails. One idea is that justice includes therapeutic jurisprudence. This is the theory that justice can and should be therapeutic. Wexler (2014), one of the first to explore the field of therapeutic jurisprudence, explains that therapeutic jurisprudence views the law as a therapeutic agent with the potential to do great good or great harm to the psychosocial aspects of the humans it touches. Because of this, the justice system can be used to do more than punish—it can be used to rehabilitate. In this theory, adequate treatment for the mentally ill *is* one of the functions of the justice system. Thus, jails and prisons can be more than vehicles for punishment, they can also be places of restoration. If this is the case, if correctional facilities are indeed to serve as places of healing and not only places of punishment, then the individuals locked behind prison and jail walls deserve care that will facilitate recovery. Thus, it is lawful, ethical, and prudent to provide care to mentally ill inmates.

Time

Another argument many may have against the better treatment of mentally ill inmates is simply time constraints. Realistically, there are many mentally ill inmates who are in and out of the correctional facilities too quickly for therapy sessions to do any good. Jails especially do not have time to implement many of these interventions effectively. When inmates are staying only a week, or some even only a day or two, how do you effectively incorporate interventions such as therapy?

While it is true that short-stay inmates may not benefit from in-facility therapy, it is not the case that they would not benefit from the other interventions suggested. This is especially true of reintegration interventions. It is perhaps more important for short-stay inmates to receive adequate discharge planning. They are in the jail for a reason and it is important that nurses and do everything they can to prevent their rearrests. This means that actively connecting them to community resources, ensuring a pathway for medication continuity and mental health care access, and aiding with employment and housing is imperative. If these are not addressed, it is likely that that inmate will be back in a correctional facility in a matter of weeks, adding arrests to his or her record, continuing to decompensate, earning more rule-violations, and getting caught in the vicious cycle.

Malingering

Lastly, some may argue that special treatment of mentally ill inmates will encourage other inmates to fake psychiatric instability in order to receive special care. If other inmates feel that guards are more lenient toward mentally ill inmates, they will likely manipulate the system to be labeled mentally ill and in need of extra care. This is often referred to as malingering.

Fortunately, there are multiple screening tools constructed to detect malingering. If the nurses or correctional staff believe an inmate may be feigning or falsely reporting symptoms, they can follow up with these screens. The first tool is the Miller Forensic Assessment of Symptoms Test (M-FAST) which has been shown to detect blatant malingering (Vitacco & Rogers, 2005). It is a 25-question structured interview which allows the correctional nurse or provider to fully assess the inmate (Vitacco & Rogers, 2005). However, given limited staff and resources, a full interview may not always be feasible. Thankfully, there are other tools that are not interview-based. One such tool is the Structured Inventory of Malingered Symptomology (SIMS) which is

a 75-item written screen (Vitacco & Rogers, 2005). This allows correctional staff to distribute the screen to multiple inmates at a time if necessary and it has been found to have the ability to detect likely malingerers (Vitacco & Rogers, 2005). A third screen is the M-Test. Like the SIMS, this is a written screen, but with 33 true-or-false items, it is shorter and less time consuming (Vitacco & Rogers, 2005). If the inmate screens positive, then the inmate should undergo the Structured Interview of Reported Symptoms (SIRS). This is a highly reliable tool that is considered the gold standard for detecting malingering (Vitacco & Rogers, 2005). These tools can reduce the waste of resources used on malingerers while ensuring that those who truly do have mental illnesses receive the treatment they need.

Conclusion

With over one million mentally ill individuals in the criminal justice system, it is imperative that correctional treatment of mentally ill inmates meet nursing standards. This means that the care they receive must be just, equitable, effective, evidence-based, and holistic. Clearly, the current mental health care provided in correctional facilities does not meet these standards. However, according to the evidence, there are many interventions that can be implemented in U.S. jails and prisons to improve the care of one of the most vulnerable populations. It is the nurse's duty and honor to fight for these human beings created in the image of God.

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